HOSPICE MEMBERSHIP NOTICE

Michigan Department of Community Health

Fax to: (517) 373-1437

☐ **ENROLLMENT APPLICATION** ➔	1. Effective Date		
☐ **ENROLLMENT UPDATE** ➔	2. Effective Date		
☐ **DISENROLLMENT NOTICE** ➔	3. Effective Date	4. Reason Code	

PROVIDER INFORMATION:

5. Provider Name			6. Provider ID Number	7. Control Number
8. Attending Physician Name			10. Hospice Phone Number	11. Hospice FAX Number
9. Physician Address (Number & Street, Suite Number)			12. Physician Provider ID Number	13. Provider Type
City	State	ZIP Code	14. Is this Beneficiary a MI-Choice Waiver Participant? ☐ **YES** ☐ **NO**	

NURSING FACILITY INFORMATION:

15. Nursing Facility Name		16. N.F. Provider ID Number	17. Date Admitted to Nursing Facility
18. Nursing Facility Address (Number & Street)		City	State / ZIP Code

BENEFICIARY INFORMATION:

19. Beneficiary Name (Last, First, Middle Initial)			21. Beneficiary ID Number	
20. Beneficiary Address (Number & Street)			22. Social Security Number	23. Birth Date
City	State	ZIP Code	24. Gender ☐ **Male** ☐ **Female**	25. Home Phone Number
26. CSHCS Beneficiary? ☐ **YES** ☐ **NO**	27. Beneficiary LOC		28. Previous Hospice Enrollee? ☐ **YES** ☐ **NO**	29. Estimated Remaining Life Span Months
30. Legal Parent or Guardian Name (Last, First, Middle Initial)			31. Diagnosis Code(s)	

OTHER HEALTH INSURANCE:

32. Insurance Company Name		33. Policy Holder Name	
34. Policy Number	35. Group or Contract Number	36. Medicare Eligibility *(check one)* ☐ **Part B** ☐ **Parts A & B**	37. Medicare Claim Number

REMARKS:

38.

☐ By placing an "X" or a "✓" in this box, I certify that I have read (or they have been read to me) and understand the Conditions of Enrollment and Certification provisions on Page 2 of this form. Any questions I had about these provisions or my hospice care were answered by a hospice representative.

For ENROLLMENT Only	
39. Beneficiary (or authorized representative) Signature	Date
40. Witness Signature	Date

For DISENROLLMENT Only	
41. Beneficiary (or authorized representative) Signature	Date
42. Witness Signature	Date

AUTHORITY: Title XIX of the Social Security Act **COMPLETION:** Is Voluntary, but is required if Medical Assistance program payment is desired.	The Department of Community Health is an equal opportunity employer, services and programs provider.

CONDITIONS OF ENROLLMENT:

Hospice services are an option of medical care that you may choose while you are in the terminal stages of your illness. Palliative at-home care is the basis for hospice care. If you do not have a family member or friend to care for you in your home, hospice care may be provided while you are a resident of an approved nursing facility (NF), home for the aged, adult foster care facility (AFC) or licensed hospice long term care unit. All Medicaid and any approved Children's Special Health Care Services (CSHCS) covered services for the terminal illness will be provided by the hospice. You must use your Medicaid identification card (ID), health plan card, or CSHCS Eligibility Letter to obtain care from your private physician or health plan for services not related to the terminal illness. You may elect to disenroll from the hospice at any time by signing the disenrollment form.

CERTIFICATION:

By signing this form, I certify that I voluntarily apply for hospice enrollment for myself or the person indicated in item number 19. The enrollment is effective on the date entered on item number 1 and will continue as long as the hospice continues operation and eligibility continues under the Medicaid Program or CSHCS approval. If my Medicaid ID card indicates a patient pay amount, I understand that I must pay that amount, **each month**, to the hospice for my care. Any applicable patient pay amount, insurance payment, and Medicaid reimbursement represents payment-in-full to the hospice. I understand and accept the conditions of enrollment stated above. I authorize any physician or hospital to release medical information to the hospice. I authorize the hospice to release medical information to the Michigan Department of Community Health.